

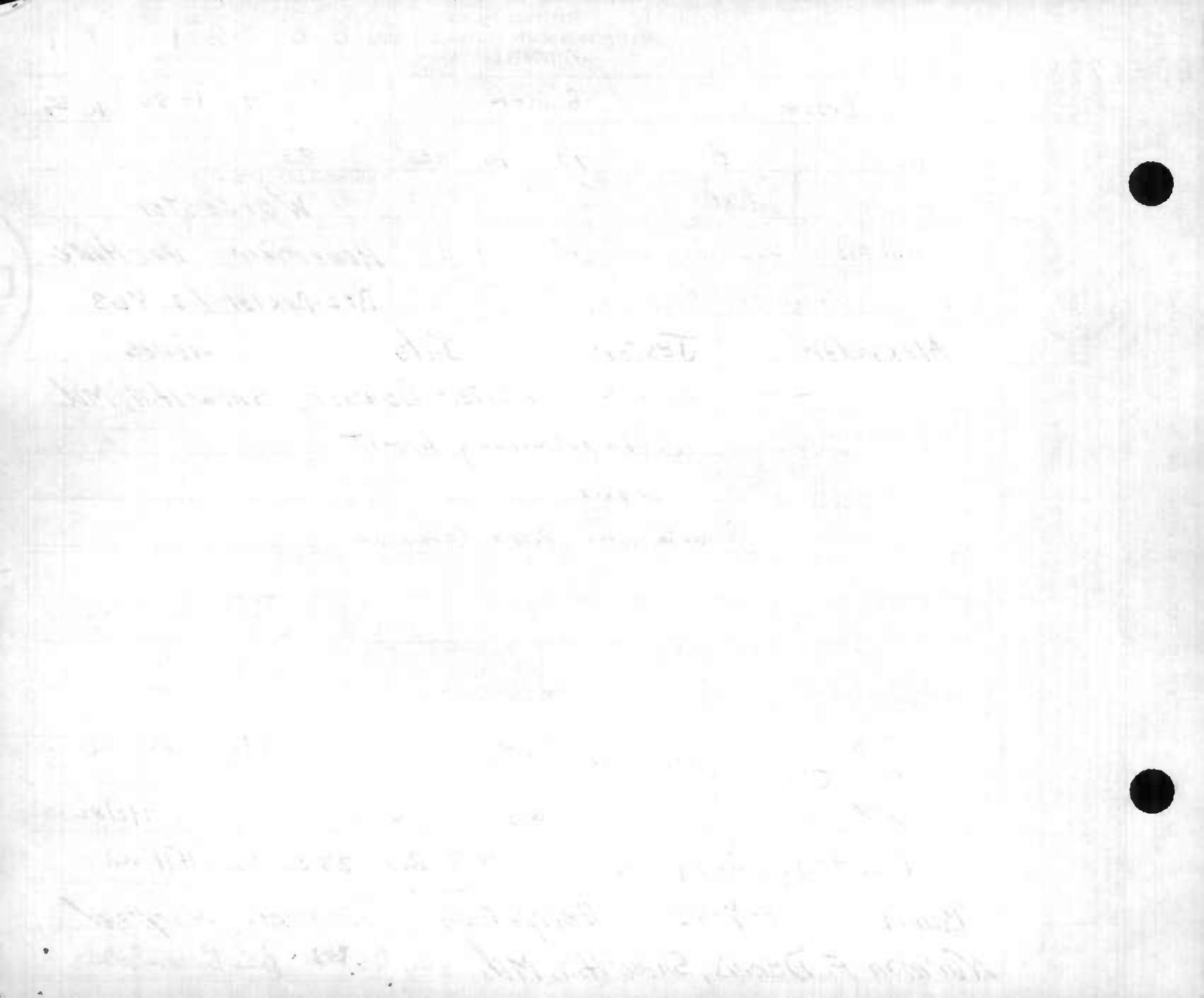
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 21 is marked to show any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 21471		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE			LAST			20. DATE OF DEATH MONTH DAY YEAR		26. HOUR		
Lessie					Bowser			7 1 86		10 30 PM		
3. SEX		4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Female		B2			12 19 02			83		MONTHS DAYS HOURS MIN.		
87. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Pocomoke, Md.		USA						Worcester				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Snow Hill, Md.		Harrison House - Snow Hill						Homemaker		Over House		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
MD		Worcester		Snow Hill		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RT 2 Box 101 / 21863				
14. FATHER'S NAME FIRST MIDDLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Alexander		Ida Jones										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO		231-16-0607			Lester Bowser, Snow Hill, Md.							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic Pelvic Carcinoma</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6/30</u> , 19 <u>86</u> , to <u>7/1</u> , 19 <u>86</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive <u>above</u> , <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.												
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						7/2/86				
Robert J. Reilly MD		RT 3 Box 232 Snow Hill, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23b. REGISTRAR'S SIGNATURE	
Burial		7-7-86		Georgetown			Pocomoke, Maryland		JUL 09 1986		Julia Dawson, Registrar	
24. FUNERAL DIRECTOR NAME		ADDRESS										
Norman F. Dennis, Snow Hill, Md.												
DHMH - 16 60M 7/84 (VRA 15, 4)												



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 1 4 7 2

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20 DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Virginia			E	Ila	Brach	07	10	86			
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female		Caucasian		MONTH	DAY	YEAR	97			IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.	
North Carolina		U.S.A.					Worcester				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
Pocomoke City		Hartley Hall Nursing Home			housewife			1108 Cedar Street 21851			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE			
Maryland		Worcester		Pocomoke City		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1108 Cedar Street			
14 FATHER'S NAME		FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME		ADDRESS				
John			W	Lewis	Sirilda		1108 Cedar Street				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		Pocomoke City, Md.					
no		213 07 7631		Nicholas Brach							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Renal Failure											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) Uremia											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-18, 1986, to 7-10, 1986, that (I) (we) last saw the deceased alive on 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (and) not view the body after death											
22b. SIGNATURE J. G. Santiano		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/10/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS									
J. G. Santiano		100 8th St., Pocomoke City, Md. 21851									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		7/12/86		Rehobeth Baptist Cem. Rehobeth Somerset Md.							
24 FUNERAL DIRECTOR NAME		ADDRESS			25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
Scott S. Nelson		Pocomoke City, Md.			JUL 16 1986			J. G. Santiano			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the attending physician and the funeral director, then please remove carbon paper and attach to the burial permit. Then please remove carbon paper and attach to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 25 is marked or Item 28 is marked, the death certificate must be filed within 72 hours after death.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 2 1 4 7 3
7 12 86
7:15 A.M.

1. DECEASED NAME (TYPE OR PRINT)	FIRST Aleen	MIDDLE T.	LAST Dennis	2a. DATE OF DEATH MONTH 12	MONTH DAY 7	YEAR 06	2b. DAY 7	YEAR 12 86	2b. HOUR 7:15 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 12			DAY 7	YEAR 06	6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester County		
10. CITY OR TOWN OF DEATH Berlin, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SURFACE FACILITY, GIVE STREET ADDRESS) Berlin Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK, OCCUPATION OR WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Pine Bluff Village 21801			
14. FATHER'S NAME FIRST William		MIDDLE C.	LAST Taylor	15. MOTHER'S MAIDEN NAME FIRST Sophia			MIDDLE Heller	LAST Taylor	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 218-50-1947			17. INFORMANT Betty F. Martin			ADDRESS Cape Charles, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Secondary to CVA</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Federico Arthes</u>			DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/14/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Federico Arthes, M.D.			22e. ADDRESS 3 Bay St., Berlin, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-14-86	23c. NAME OF CEMETERY OR CREMATORIAL Cape Charles Cem.			23d. LOCATION CITY OR TOWN Cape Charles	COUNTY	STATE Virginia	
24. FUNERAL DIRECTOR NAME Guy J. Doughty		ADDRESS Cape Charles, Virginia			25a. DEATH BY REGISTRAR SUL 17 1986				
					25b. REGISTRAR'S SIGNATURE				

BP _____

DHMH-16 25M
(VRA 15, 4) 1/79

1

TO HOSPITAL OR ATTENDING PHYSICIAN. The patient is retained by the hospital or attended physician.

death. Page 4 may be
funeral director. page 3
72 hours after death
choice

100

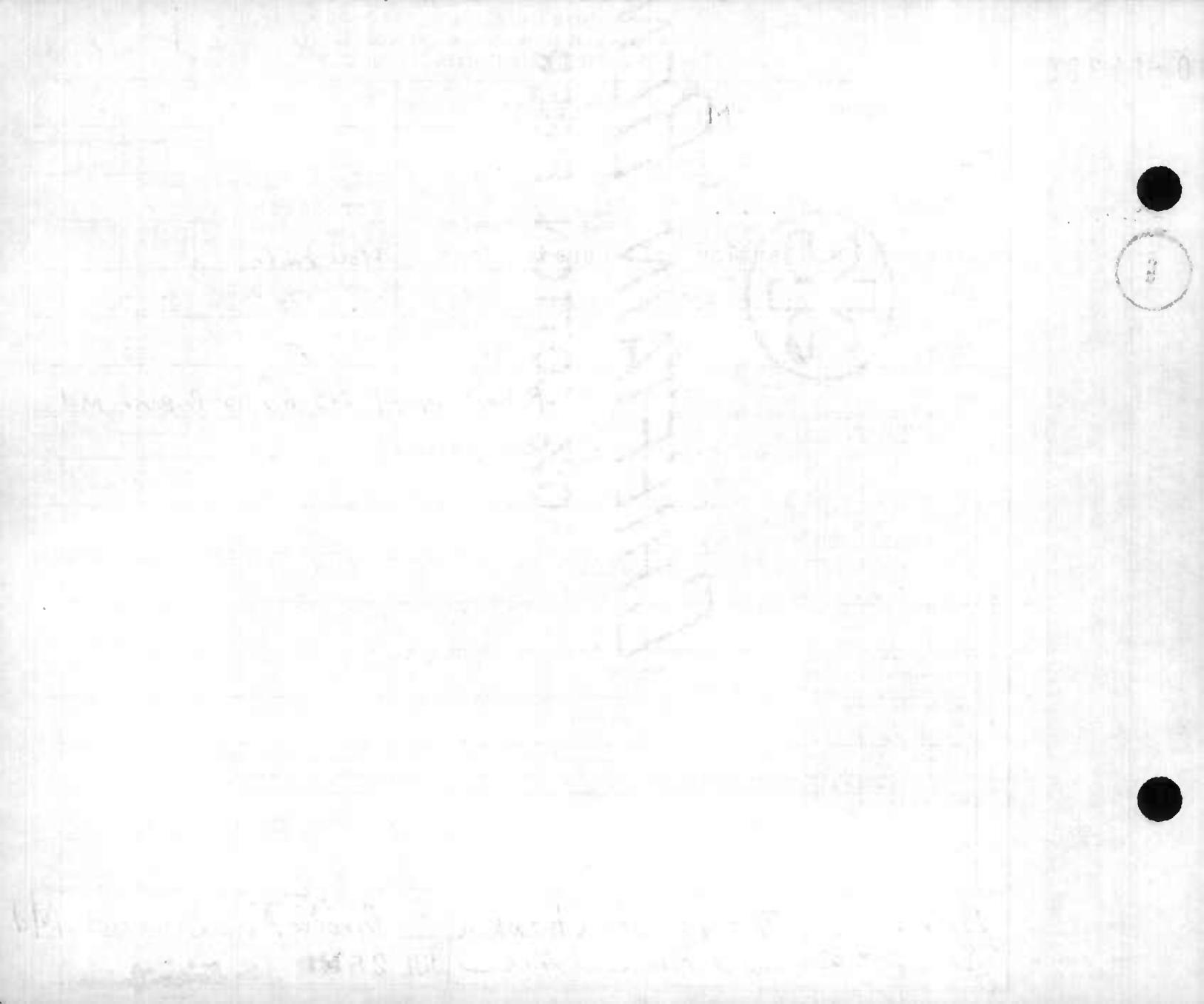
MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 1 4 7 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Susan M. Ferrell			2a. DATE OF DEATH 07 16 86	MONTH YEAR 5:35 p.m.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH 04 DAY 28 YEAR 04	6. AGE (IN YEARS LAST BIRTHDAY) 82	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.	
10. CITY OR TOWN OF DEATH Pocomoke City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartley Hall Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
13a. STATE Maryland	13b. COUNTY Somerset	13c. CITY OR TOWN Princess Anne	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rt. 2 box 110 21853
14. FATHER'S NAME FIRST John	MIDDLE E.	LAST Taylor	15. MOTHER'S MAIDEN NAME FIRST Mary	MIDDLE LAST Ross
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO 111 20 0606	17. INFORMANT Robert Ferrell, Rt 2 Box 110 Pr Anne, MD	18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE				
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD				
DUE TO, OR AS A CONSEQUENCE OF (c) HTN				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
DIABETES				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (D) (this hospital) attended the deceased from APRIL 19 86 to JULY 16 1986, that (D) (we) lost saw the deceased alive on JULY 16 1986, and that in (our) opinion death occurred on the date and hour and from the causes stated (D) (we) (D) (did) not view the body after death.				
22b. SIGNATURE Robert Allen	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7/17/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT ALLEN	22e. ADDRESS 305 10th St., Pocomoke, MD. 21851			
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE 7/17/86	23c. NAME OF CEMETERY OR CREMATORIAL Perrybank	23d. LOCATION CITY/TOWNSHIP Princess Anne, Somerset, MD.	23e. STATE MD.
24. FUNERAL DIRECTOR James S. Lissman Funeral Home	25a. DATE REC'D. BY REGISTRAR JUL 25 1986		25b. REGISTRAR'S SIGNATURE Julia Diane Wallace	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1A. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 3 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL. BALTIMORE, MARYLAND, 21201

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 21475
1- STATE REGISTRAR			2a DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR ESTI- DEATH MATED <input type="checkbox"/> July 19 1986 1258P									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b HOUR						
MARY JANE FOREMAN												
SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS) LAST BIRTHDAY	7 IF UNDER 1 YR.	8 IF UNDER 24 HRS.	9 DATE MONTH DAY YEAR	2d HOUR					
FEMALE	NEGRO	4 15 86	84 YRS.	MONTHS DAYS	HOURS MIN	July 19 1986	135P					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
MD			U.S.A.						WORCESTER			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
NEWARK			RT. # 1, BOX 60			DOMESTIC			HOUSEWIFE			
13a STATE MD			13b COUNTY WORCESTER			13c CITY OR TOWN NEWARK			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
HARRY			EMMA									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO, NO, OR UNKNOWN			16b. SOCIAL SECURITY NO. 220-66-4849			17. INFORMANT VIRGINIA FOREMAN			ADDRESS SAME			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Peter S. Abbott</u>			TITLE (SPECIFY) M.D. <u>Deputy</u>			MEDICAL EXAMINER			DATE SIGNED <u>July 19, 1986</u>			
EXAMINER'S NAME (TYPE OR PRINT)			PETER S. ABBOTT			ADDRESS P.O. BOX 32 BERLIN, MD. 21811						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 7-26-86			23c. NAME OF CEMETERY OR CREMATORIUM WMS A.M.E. CHURCH CEMETERY			23d. LOCATION CITY OR TOWN NEWARK COUNTY WORCESTER STATE MD			
24. FUNERAL DIRECTOR NAME <u>Jolley Memorial Chapel</u>			ADDRESS <u>RT 2, Box 920 Salisbury, MD</u>			25a. DATE REC'D. BY REGISTRAR 24.1986			25b. REGISTRAR'S SIGNATURE <u>John J. Abbott</u>			
DHMH - 17 (VR A15 ME (5))												

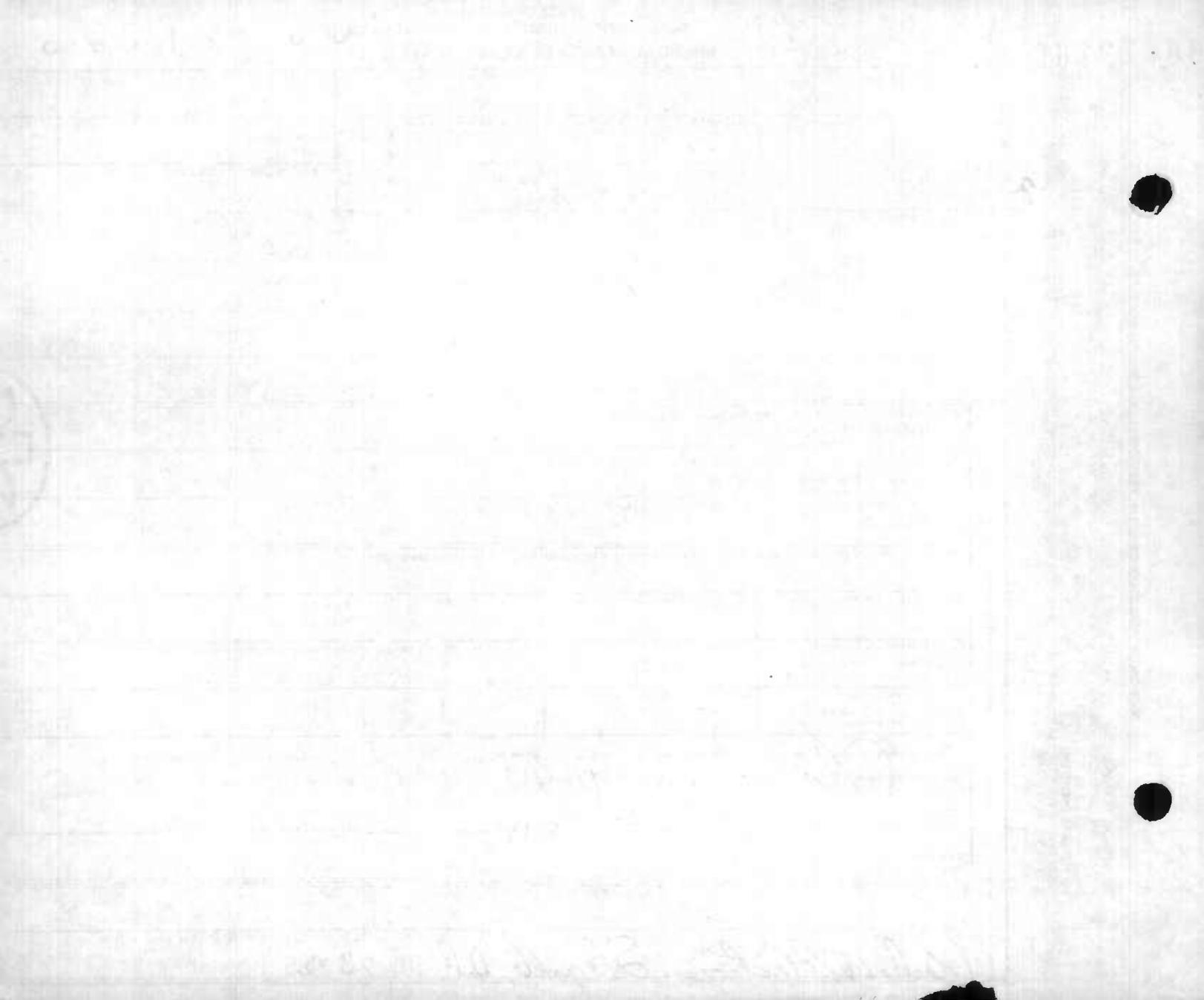
Second edition

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

86 21476
REG. NO.

1- STATE REGISTRAR		1. DECEASED NAME FIRST MIDDLE LAST						7a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR	
		EVERETT H. GODFREY						7-19 1986		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS	MONTHS	DAYS	HOURS	MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR	
Male	White	October 4 1970	15 yrs.							7-19 1986 8:30 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Delaware		USA								Worcester County, MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bishopville		Rt.1 Box 81						Student		21813	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Worcester		Bishopville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt.1 Box 81		21813	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Bobby W. Godfrey		Janet Wright									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.						17. INFORMANT		ADDRESS	
No		213-76-0705						Everett B. Godfrey, Bishopville, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contact gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? Head only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7/19 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21e. LOCATION STREET CITY OR TOWN COUNTY STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK		house		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		Route #1, Box 18, Bishopville, Worcester Co., MD					
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. AUTOPSY <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		22c. TITLE (SPECIFY)		22d. Chief MEDICAL EXAMINER				DATE SIGNED 7/20/86	
ACTUAL SIGNATURE		John E. Smialek, M.D.		ADDRESS 111 Penn St., Baltimore, Md. 21201							
EXAMINER'S NAME (TYPE OR PRINT)		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE	
BP		Burial		July 23, 1986		Zion Church Cemetery		Bishopville		Worcester MD	
DHMH - 17 (VR A15 ME (5))		24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
		Paul W. Hart, Sallville, Del.		JUL 23 1986		Julie Davidson					



TO HOSPITAL ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of the time it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and executed within 24 hours of the time it may be retained by the hospital or attending physician, then please remove carbon papers, sign and file it in the burial transit permit. Then please remove carbon papers, sign and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate should be detached for use as the burial transit permit. Then please remove carbon papers, sign and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 2 1 4 7 7
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH MONTH DAY YEAR			25a. HOUR 2:15 P.M. 2 P.M.		
Violet					Harting	7/7/86					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE IN YEARS LAST BIRTHDAY		25b. HOUR 2:15 P.M. 2 P.M.		
Female		Caucasian		03 02 1903			83 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.		
Delaware		U.S.A.		NEVER MARRIED DIVORCED			Worcester				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Pocomoke City		Hartley Hall Nursing Home		Homemaker							
13a. STATE Maryland						13b. COUNTY Worcester		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
										13e. STREET ADDRESS / ZIP CODE St. Lukes Road Route 9	
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST		
John				Lindsay	Maria			E.	Foster		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
no			221 07 1494D			Donald Harting (Son) Salisbury, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for Part I. DEATH WAS CAUSED BY.) IMMEDIATE CAUSE (a)						PULMONARY EDEMA PULMONARY EDEMA					
DUE TO, OR AS A CONSEQUENCE OF (b) POSS. RECURRENT PULMONARY EMBOLUS						POSS. RECURRENT PULM. EMBOLUS					
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a PULMONARY EMBOLUS 3 WKS. AGO											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>JULY 10 1986</u> to <u>JULY 2 1986</u> , that (1) we lost saw the deceased alive on <u>JULY 7 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert Allen			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/7/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Allen ROBERT ALLEN			22e. ADDRESS 305 10th St. Pocomoke, Md. 21856 305 10 st. Pocomoke 21856								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/14/86			23c. NAME OF CEMETERY OR CREMATORIAL Lombardy Cemetery			23d. LOCATION CITY OR TOWN Wilmington, N. C., Delaware COUNTY STATE		
24. FUNERAL DIRECTOR NAME Holloway Funeral Home, P.A., Salisbury, Maryland			25a. DATE REC'D. BY REGISTRAR JUL 14 1986			25b. REGISTRAR'S SIGNATURE John J. Holloway					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified of the same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	6	2	1	4	7	8
										REG. NO. 00-1344						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Lester Marvin Holland, Jr.						7 23 86						8:01 AM				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White			MONTH 4 DAY 7 YEAR 08			78			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
MD			USA						Worcester							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Berlin			Berlin Nursing Home, Berlin, MD			Builder/Carpenter/FARMER										
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
MD			Worcester			Berlin			Rt. 2, Box 31 21811							
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
Lester Marvin Holland, Sr.			Bessie Casper Holland													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
NO			212-16-7932			Berlin Nursing Home, Berlin, MD 21811										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Candid resp Arrest.</i>																
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASVD. Severe -</i>																
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diage.</i>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (1) (this hospital) attended the deceased from <i>April 1. 1986</i> to <i>July 19, 1986</i> , that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Dr. Federico Arthes</i> DEGREE										22c. DATE SIGNED <i>7-23-86</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
Dr. Federico Arthes										3 Bay Street, Berlin, MD 21811						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN							
Burial			7/26/86			Evergreen Cemetery			Berlin Worcester County Maryland State							
24. FUNERAL DIRECTOR NAME <i>W. Kirk Burbage</i>										25a. DATE REC'D. BY REGISTRAR <i>JUL 25 1986</i> 25b. REGISTRAR'S SIGNATURE <i>W. Kirk Burbage</i>						
108 Williams Street Berlin, MD 21811																
DHMH - 16 50M 4/82 (VRA 15, 4)																

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11121-001

00-14105

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH21479
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN PART 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT FORM. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PENNIN STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- FOR
STATE
REGISTRAR1 DECEASED NAME
(TYPE OR PRINT)FIRST
PaulMIDDLE
C.LAST
Long2a DATE KNOWN
OF
DEATH
MATEDMONTH
JULYDAY
29YEAR
19862b HOUR
1100P

3 SEX

4 RACE

5 DATE OF BIRTH
MONTH DAY YEAR6 AGE (IN YEARS
LAST BIRTHDAY)7 IF UNDER 1 YR.
MONTHS DAYS8 IF UNDER 24 HRS.
HOURS MIN9 BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

10 CITIZEN OF WHAT COUNTRY?

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)12b. KIND OF BUSINESS
OR INDUSTRY

12 CITY OR TOWN OF DEATH

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

14 FATHER'S NAME

15 MOTHER'S MAIDEN NAME

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17 INFORMANT

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(YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17 INFORMANT

ADDRESS

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(YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17 INFORMANT

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(YES, NO, OR UNKNOWN)

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(YES, NO, OR UNKNOWN)

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17 INFORMANT

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(YES, NO, OR UNKNOWN)

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17 INFORMANT

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(YES, NO, OR UNKNOWN)

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(YES, NO, OR UNKNOWN)

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17 INFORMANT

ADDRESS

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(YES, NO, OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17 INFORMANT

ADDRESS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

002-13524

1- FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 6 21480

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Florida Simpson MARTIN						July 17 1986				405 AM		
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. HOUR		
Female			White	MONTH	DAY	YEAR	78	IF UNDER 1 YEAR		IF UNDER 24 HRS		
				Oct	7	1907	YRS.	MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Md			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>			Worcester			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
RI Ocean City			Po Box 3 Ocean City (MD)			Housewife			—			
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Md			WOR Ocean City						28m St 21842			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST			
Charles					SIMPSON	MARY ANN			SIMPSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			218-12-1045			Colleen E. Pace			3 Aug 1981 Berlin			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c).			DUE TO, OR AS A CONSEQUENCE OF (b)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 years			
									9 years			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			
22a. I certify that (I) (we) attended the deceased from			July 16 1986			19			to July 17 1986			
saw the deceased alive on			July 16 1986			19			19			
above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
Francis J. Townsend Jr.									July 17, 1986			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
Francis J. Townsend Jr.			1001 Philadelphia Ave Ocean City MD 21842									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			
Burial			7/19/86			Sunset Memorial Pk			Berlin Worcester MD			
24. FUNERAL DIRECTOR NAME			108 Williams Street			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
W. Kirk Burbage, Berlin, MD 21811						JUL 21 1986			Lisa Jackson-Randee			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3, TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.			
0-12268			21481												
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST				
WATTERSON									MILLER						
2. SEX		3. RACE		4. DATE OF BIRTH MONTH DAY YEAR		5. AGE (IN YEARS LAST BIRTHDAY)		6. IF UNDER 1 YR.		7. IF UNDER 24 HRS.		8. DATE KNOWN <input type="checkbox"/> OF ESTI- DEATH MATED <input checked="" type="checkbox"/> July 9 1986		9. MONTH DAY YEAR	
MALE		WHITE		11/21/02		83 yrs.		MONTHS		DAYS		HOURS		MIN	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
KENTUCKY		U.S.A.									WORCESTER				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
OCEAN CITY		HARBOR ROAD			MAINTENANCE			MOTEL INDUS							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS							
MARYLAND		WORCESTER		OCEAN CITY		X		HARBOR ROAD							
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME							
WILLIAM		A.		MILLER				MILBREY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO		16b. SOCIAL SECURITY NO.		16c. INFORMANT		16d. ADDRESS		16e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
		217-36-6052		MRS. JOHN DALE SHOWELL		37th St & Ocean City, MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.															
} (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Peter S. Abbott</u>		TITLE (SPECIFY) M.D. <u>Deputy</u>		MEDICAL EXAMINER		DATE SIGNED <u>July 9, 1986</u>									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <u>P.O. Box 32 BERLIN, MARYLAND 21811</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 7/10/86		23c. NAME OF CEMETERY OR CREMATORIAL DELMARVA CREMATORY		23d. LOCATION CITY OR TOWN <u>LEWES</u>		23e. COUNTY <u>SUSSEX</u>		23f. STATE <u>DELAWARE</u>					
CREMATION															
24. FUNERAL DIRECTOR NAME		108 Williams Street		25a. DATE REC'D. BY REGISTRAR <u>1986</u>		25b. REGISTRAR'S SIGNATURE <u>John Kirk Burbage</u>									
W. KIRK BURBAGE		Berlin, Maryland 21811													
07/84 25M		BP													
DHMH - 17		(VR A15 ME (5))													

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2 1 4 8 2

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
William Henry Scott						7	1	86	4:15 A M					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		MONTH	DAY	YEAR	76	YRS.			MONTHS	DAYS	HOURS	MIN.
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD				
MD		USA					Worcester							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Berlin		Berlin Nursing Home, Berlin, MD		Lawyer										
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												21811		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
MD		Worcester		Berlin		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			204 S. Main Street					
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME			16. ADDRESS			LAST		
Edward		Marshall		Scott		Matilda			Dr. Paul A. Scott, Broad Street,			Trimper		
6b. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		7b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
YES		WW II		213-18-4172			Berlin, MD 21811			IMMEDIATE				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u>												YEARS		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSION</u>												YEARS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>EMPHYSEMA, ALZHEIMER'S DISEASE, PNEUMONIA</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____										
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July</u> , 19 <u>76</u> , to <u>July</u> , 19 <u>86</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>July</u> , 19 <u>86</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death.														
22b. SIGNATURE <u>Paul A. Scott, M.D.</u>		22c. DEGREE <u>MD</u>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>7/1/86</u>							
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PAUL A. SCOTT, M.D.</u>		22g. ADDRESS <u>24 BROAD ST. BERLIN, MD. 21811</u>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>7/3/86</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>St. Paul's Churchyard</u>			23d. LOCATION CITY OR TOWN <u>Berlin</u>			COUNTY <u>Worcester</u>		STATE <u>MD</u>		
24. FUNERAL DIRECTOR <u>W. Kirk Burbage,</u>		24a. DATE REC'D. BY REGISTRAR <u>JUL 2 1986</u>		24b. REGISTRAR'S SIGNATURE <u>J. Kirk Burbage</u>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1 - STATE REGISTRAR			8 REG. NO. 214363								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR		
Florence Viola Selby									July 24, 1986		
3. SEX Female			4. RACE Black			5. DATE OF BIRTH MONTH 6 DAY 27 YEAR 32			6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Somerset WOR. MD.		
10. CITY OR TOWN OF DEATH Pocomoke			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		
13a. STATE Md.			13b. COUNTY Somerset			13c. CITY OR TOWN Pocomoke			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Finnison Custis						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Iva Kane					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 218-24-4894			17. INFORMANT Ray Selby			ADDRESS Stockton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>carcinoma of pancreas + liver</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) _____								
			(c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on _____ 19 _____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) did not view the body after death.			7/28 19 86			to 7/28 19 86					
22b. SIGNATURE <i>Charles B. Silvia Jr MD</i>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/28/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles B. Silvia Jr MD			22e. ADDRESS 540 Riverside Drive Salisbury MD 21801								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-28-86			23c. NAME OF CEMETERY OR CREMATORIAL Mt Sinai			23d. LOCATION CITY OR TOWN Stockton COUNTY Worcester STATE Md.		
24. FUNERAL DIRECTOR NAME Keith E. H. Wharton			ADDRESS Accomac, Va. 23301			25. DATE RECORD IS REGISTERED AUG 5 1986					

1950-1951

1950



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after it is filed in my funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 4 and 5 will be filed within 72 hours after death.

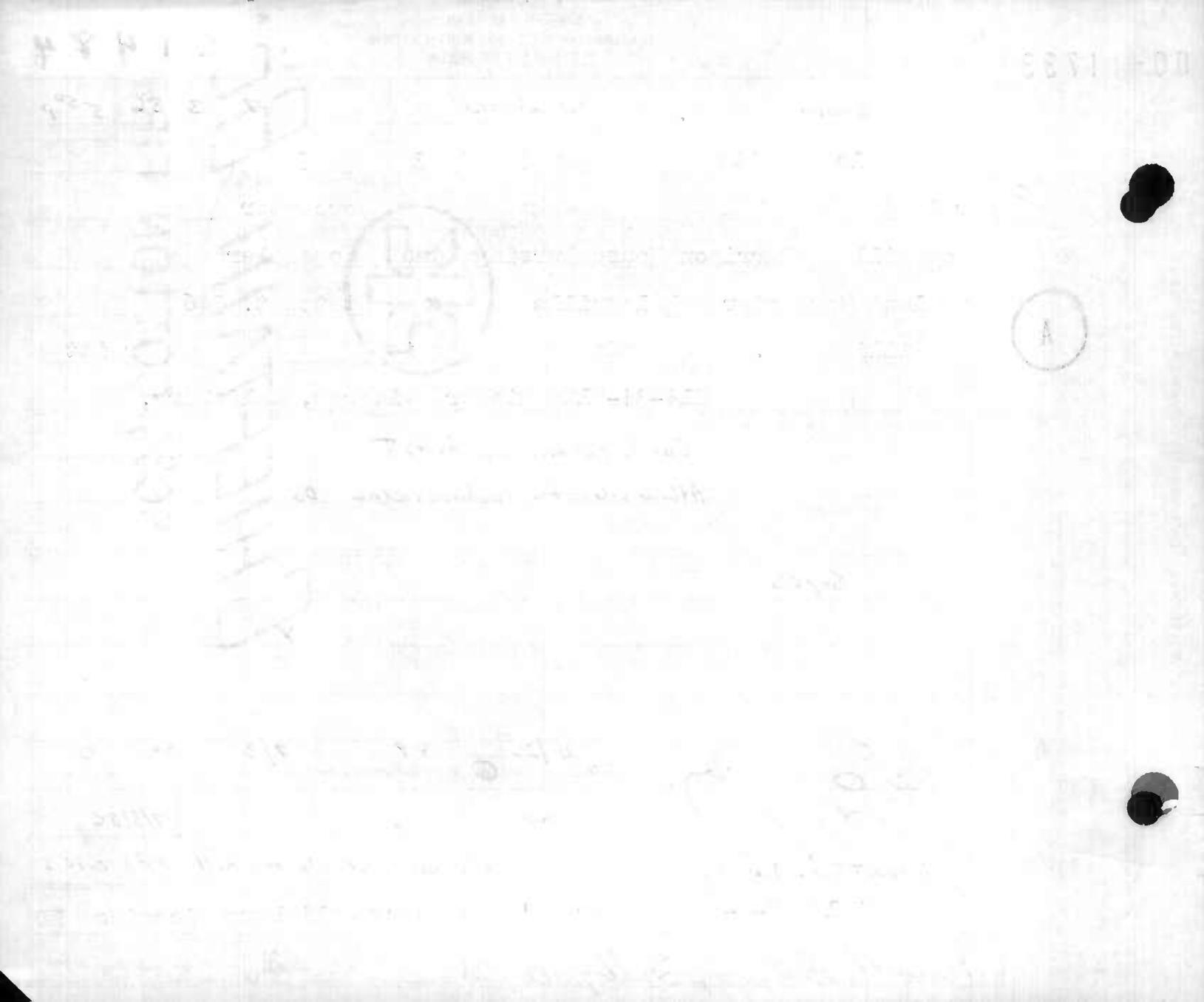
Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in my funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 4 and 5 will be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked on Item 18 show any injury, or other traumatic event, the medical

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 86 21484
1. FOR STATE REGISTRAR			2. DATE OF DEATH 7 3 86			20. HOUR 5:50 P.M.
1. DECEASED NAME (TYPE OR PRINT)		FIRST Laura	MIDDLE B.	LAST Wimbrow		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH May DAY 9 YEAR 1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.
10. CITY OR TOWN OF DEATH Snow Hill		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harrison House Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13. STATE Maryland		13b. COUNTY Worcester		13c. CITY OR TOWN Whaleyville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST William		MIDDLE F.	LAST Bounds	15. MOTHER'S MAIDEN NAME FIRST Bessie		MIDDLE LAST Truitt
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-34-9125		17. INFORMANT Richard Wimbrow, Salisbury, MD		ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Sepsis</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>11/26</u> , 19 <u>86</u> , to <u>7/3</u> , 19 <u>86</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>7/2</u> , 19 <u>86</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death.						
22b. SIGNATURE <u>Robert P. Reilly</u>		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 7/3/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert P. Reilly</u>		22e. ADDRESS Rt 3 Box 232 Snow Hill Md. 21863				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-7-86		23c. NAME OF CEMETERY OR CREMATORIAL Parson's Cemetery		23d. LOCATION CITY OR TOWN Salisbury COUNTY Wicomico STATE MD
24. FUNERAL DIRECTOR <u>Charles W. Hart</u>		ADDRESS <u>Selbyville, Del.</u>		25a. DATE REC'D. BY REGISTRAR JUL 8 1986		25b. REGISTRAR'S SIGNATURE <u>John W. Anderson</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in the presence of a physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

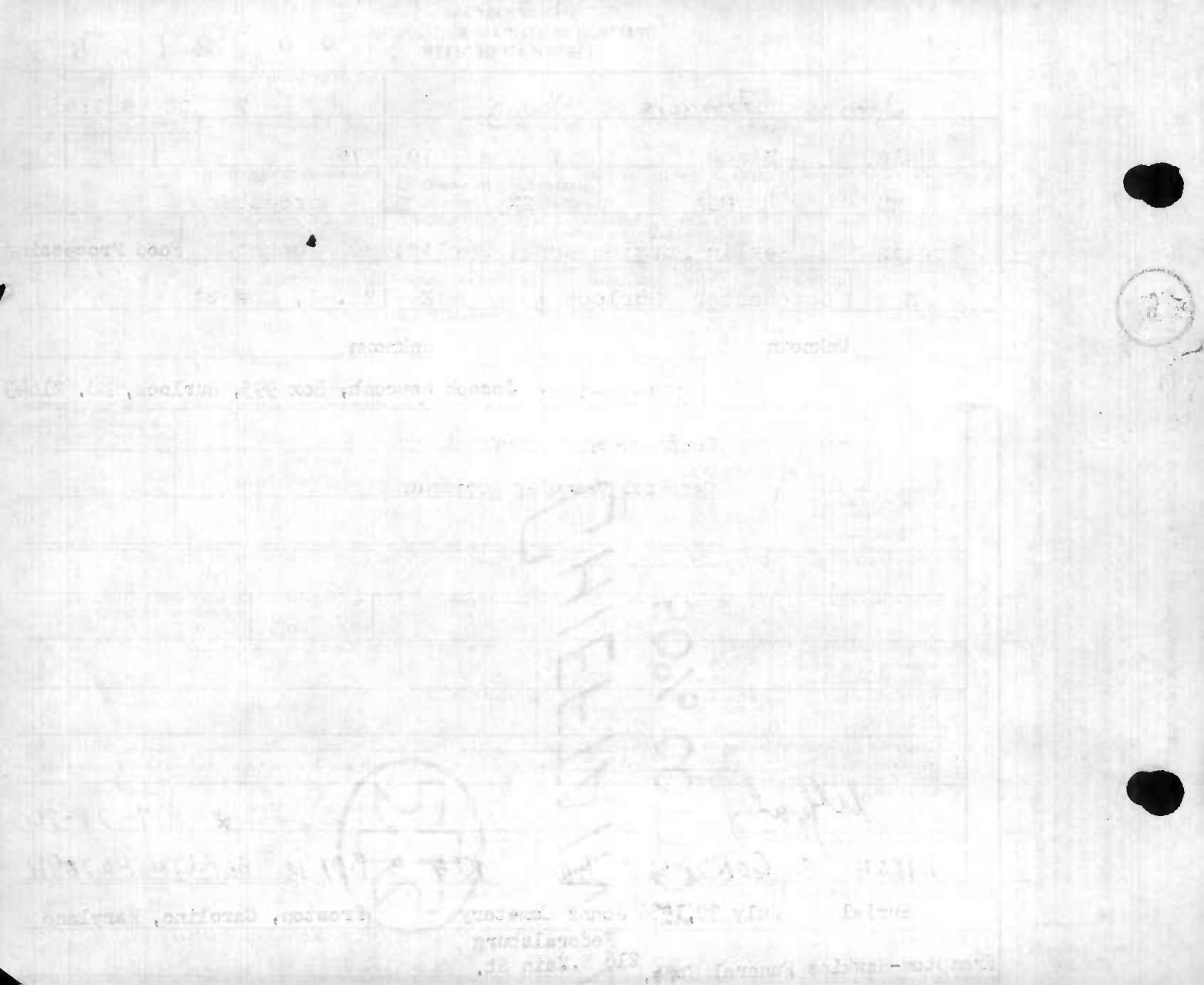
IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner shall be notified of same.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 2 1 4 8 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
James Francis Young						7	28	86	1:45AM						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
Male		Black		MONTH	DAY	YEAR	76	YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH					
MD		USA					Worcester			Berlin					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE						
Berlin Nursing Home, Berlin, MD			Unknown			Food Processing			MD						
13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Dorchester			Hurlock			YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	Rt. 1, Box 21A			21643				
14. FATHER'S NAME FIRST			15. MOTHER'S MAIDEN NAME FIRST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
Unknown			Unknown			NO			217-05-1645			Joseph Newcomb, Box 995, Hurlock, Md. 21643			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u>															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular Accident</u>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/>		NO <input type="checkbox"/>		YES <input type="checkbox"/>		NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Lilah C. Gonzalez H.D.</u> DEGREE															
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>															
22c. DATE SIGNED <u>7-28-86</u>															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
LILAH C. GONZALEZ H.D.		RTB-3 BOX 13 BERLIN, MD 20811													
23a. BURIAL, CREMATION, REMOVAL (SPEC#)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE				
Burial		July 30, 1986		Johns Cemetery			Preston		Caroline		Maryland				
24. FUNERAL DIRECTOR NAME <u>Frampton-Hawkins Funeral Home</u> ADDRESS <u>216 N. Main St.</u> 25a. DATE REC'D. BY REGISTRAR <u>AUG 05 1986</u> 25b. REGISTRAR'S SIGNATURE															
DMMH - 16 50M 4/B2 (VRA 15, 4)															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please send to the State Department of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8621480						
REG. NO.																		
1. DECEASED NAME			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
ROSE						ZARETSKY			7		31	1986	10:15 P.M.					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
FEMALE			WHITE			MONTH 7 DAY 15 YEAR 1905			81			MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
ROSSIA			USA						WORCESTER COUNTY									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
BERLIN, MD.			BERLIN NURSING HOME			SALESWOMAN												
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
MD.			WORCESTER			OCEAN CITY			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			10900 COASTAL HIGHWAY						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME															
HEIMAN			DORA BLUM															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT												
NO			164-07-1681 A			S. GASTON BERLIN, MD												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																		
DUE TO, OR AS A CONSEQUENCE OF (b)																		
BRAIN TUMOR - PATHOLOGY ??																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 31</u> , 19 <u>84</u> , to <u>July 31</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>July 31</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE			DEGREE															
Federico Arthes, M.D.																		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS			22f. DATE SIGNED									
FEDERICO ARTHES, M.D.						3 BAY ST., BERLIN, MD. 21811			Aug 1-86									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY						
Burial			8-3-86			SHALOM M.P.			LUR. MORTUARIES			Baltimore, MD.						
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
ULLRICH F.H.			Berlin, MD.						AUG 7 1986			Seth Davidson-Rendell						

